

FILED AUG 23 1947

Registration District No. 251

Primary Registration District No. 5855

Registrar's No. 177

1. PLACE OF DEATH:

(a) County Nodaway White
(b) City or town Barnard, Mo. "Rural" Cloud
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2 1/2 Miles southwest.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 47 Years
years, months or days)

3. (a) PRINT FULL NAME ANNA M. ARMSTRONG

3. (b) If veteran, _____ 3. (c) Social Security
name was _____ No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Charles S. Armstrong 6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased October 30, 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 9 7 _____ hr. _____ min.

9. Birthplace Bedison Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business None

12. Name Alexander Thompson
13. Birthplace Buchanan Co. Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Josephine Campbell
15. Birthplace Guilford Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Charles S. Armstrong
(b) Address Barnard, Missouri

17. (a) Burial (b) Date thereof 8-9-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Barnard Cemetery

18. (a) Signature of funeral director Price Funeral Home
(b) Address 120 E. 1st, Maryville, Mo.

19. (a) Aug. 11, 1947 (b) Kress Holt
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Nodaway
(c) City or town Barnard "Rural"
(If outside city or town limits, write "RURAL")
(d) Street No. 2 1/2 Miles Southwest.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 7th
year 1947 hour 8 minutes 40 P. M.

21. I hereby certify that I attended the deceased from
Sept. 5, 1942 to August 7, 1947
that I last saw her alive on August 7, 1947
and that death occurred on the date and hour stated above.
Immediate cause of death Ictus cerebri, pre- Duration
sumably thrombosis, 6 d.

Due to atherosclerosis.
Fracture r. femur. 10 w.

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: not made
Of operations _____

Of autopsy not had

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place)
While at work? _____ (e) Means of injury 0

23. Signature Chas. D. Humbert, Jr. (M. D. or other) _____
Address Barnard, Mo. Date signed 8/9/47

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN
Underline the cause to which death should be charged statistically.

DISTRICT HEALTH OFFICE
Cameron, Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

John W. Price

Licensed Embalmer No. *4281*

P. O. Address. *Maryville Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Sept 177

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Primary Registration District No. 5855

Registrar's No.

1. PLACE OF DEATH:

- (a) County nodaway
(b) City or town spaul
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

3. (a) PRINT
FULL NAMEAnna M. Armstrong3. (b) If veteran,
name war3. (c) Social Security
No.4. Sex F 5. Color or race W 6. (a) Single, widowed, married,
divorced M6. (b) Name of husband or wife 6. (c) Age of husband or wife if
alive 30 years7. Birth date of deceased Oct 30
(Month) (Day) (Year)8. AGE: Years 12 Months 12 Days 12 If less than one day
hr. 12 min. 129. Birthplace MO
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1947 year 1947 hour 12 minute 12 M.21. I hereby certify that I attended the deceased from 1947 to 1947, 1947that I last saw him alive on 1947 and that death occurred on the date and hour stated above.Immediate cause of death Cerebrovasculardisorder, ratherthan "accident,"Due to Practically thrombosis,Due to being Phagocytosis 6 days

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations g3

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature Chas. D. Franklin (M. D. or other)

Address Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

S-28496

1. *Pharmaceutical industry*—United States—History. I. Title. II. Series.